

Reviewer 1:

I reviewed the recommendations and do not have any substantial changes. I think it is an excellent copy and look forward to its public release.

Reviewer 2:

I find the document to be very well written. It reviews the relevant scientific data and makes a strong and cogent case for the recommendations that follow. In my opinion, the relevant epidemiological, clinical, laboratory, and outcomes data have been reviewed and considered in support of the case for the revised testing guidelines.

I have only one minor quibble--on page 3, paragraph 3 you note that treatment, especially the introduction of protease inhibitors and highly active antiretroviral therapy in 1995" has led to reductions in AIDS mortality. Certainly at the time of their introduction the PIs were the mainstay of HAART, but today regimens based on non-nucleoside reverse transcriptase inhibitors (NNRTI) are a mainstay of therapy and one of two recommended first-line regimens for initial antiretroviral therapy according to DHHS guidelines. In order not to give the impression that reduction in AIDS mortality is specifically related to use of a protease inhibitor as part of HAART it might be better just to modify the sentence to state "...especially the introduction of highly active antiretroviral therapy..." without being more specific.

Reviewer 3:

Comments:

- Expand on point regarding the proportion of those tested for HIV within 1 year of AIDS diagnosis as an indicator of late diagnosis.
- Change "risk assessment and prevention counseling are resource intensive" to "time consuming".
- To discussion on prevention counseling, add outcome from Project Explore, an intensive, 10 individually-delivered, theory-based counseling intervention delivered to high-risk negative MSM which showed a reduction in unprotected anal sex with HIV-positive and unknown serostatus partners, but only a trend towards lowering HIV acquisition and no reduction in HSV-2 acquisition (Lancet 2003).
- For section on acute retroviral syndrome: "an estimated 40%-90% of the 40,000 persons who acquire HIV infection each year will experience symptoms of acute retroviral syndrome." This figure is higher than most studies have found; cite Schechter, Ann Int Med 1996, 1998; Celum JID 2001; Kahn and Walker NEJM 2003, Geise, Celum 2003.
- Consider new subheading: Lessons Learned from Routine Opt-Out Antenatal HIV Testing.
- Re: **Consent and Pretest Information:** Wonder whether you need to more explicitly state that separate written consent for HIV testing is no longer recommended (so clinicians and hospitals will be able to justify to their programs and IRBs that they will no longer use existing informed consent forms.)

- Re: **Rapid HIV Tests:** Excellent. Maybe add comment on relative cost effectiveness of use of rapid HIV tests in episodic care settings.
- Consider adding a section on additional recommendations for management of recently or acutely infected persons.
- Cost-effectiveness models may underestimate the benefits of more frequent screening of high risk persons.